STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395617	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John J Kane Regional Center-SC	300 Kane Boulevard Pittsburgh, PA 15243

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to protect residents from neglect for one of four residents (Resident R1). This was identified as past non-compliance.Findings include: Review of the facility policy, Abuse - Resident and Reasonable Suspicion of a Crime dated 11/24/25, defined neglect as the failure of the facility, the staff, or service providers to provide goods and services to a resident that are necessary to avoid or may result in physical harm, pain, mental anguish, or emotional distress. Review of the clinical record indicated Resident R1 was originally admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 10/28/25, included diagnoses of morbid obesity (chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and muscle weakness. Review of Section G: indicated that Resident R1 required substantial/maximal assistance to roll left and right. Review of Resident R1's current plan of care initiated on 7/24/25, indicated At risk for injury related to falls due to decreased mobility and generalized weakness. Assist x2 for transfers and bed mobility. Review of a progress note dated 12/23/25, at 2:40 p.m. indicated, This ADON (Assistant Director of Nursing) was called to unit by LPN (licensed practical nurse) regarding a fall from bed. Upon arriving to unit, resident was found on the floor lying on her back. Resident was alert and oriented and able to answer questions appropriately. Review of a progress note dated 12/23/25, at 3:09 p.m. indicated, Resident c/o pain in head area. 911 called. Resident remained on floor until paramedics arrived. Resident fell out of bed during care. Review of a progress note dated 12/23/25, at 6:41 p.m. indicated, Received report from [hospital] and spoke to RN. Resident is said to be stable from the fall. Review of facility submitted information dated 12/23/25, indicated, CNA (nurse aide), [Employee E1] was providing care to [Resident R1]. CNA had slightly turned resident onto her right side then walked away from the resident to obtain supplies to provide incontinence care. Resident fell out of bed. RN assessed: Moderate amount of blood noted on left lower extremity from prior wound. No changes in ROM (range of motion), Neurochecks (systematic assessments of the nervous system (brain, spinal cord, nerves) evaluating mental status, cranial nerves, motor strength, sensory function, coordination, and reflexes to detect issues with movement, feeling, balance, awareness, or cognition) WNL (within normal limits). Resident did complain of neck pain when paramedics arrived. Review of emergency room physician documentation dated 12/23/25, at 6:53 p.m. [Resident R1] presents to the ED (emergency department) from skilled facility after she had a fall out of bed with head injury. She is complaining of pain in her head, neck, shoulder, back, also has bleeding through the bandages on her chronic left wound. Review of the facility provided unit assignment sheet in use on 12/23/25, indicated Resident R1: BED MOBILITY: 2 ASST. Review of an employee (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement written by NA Employee E1 dated 12/23/25, indicated, I was doing care on resident. I went to slid her toward me then roll her towards the door. I roll her halfway towards the window then I went for a wash rag and towel then I hard to resident fell on the floor. I ran to check on the resident then ran to the door the other aide came in that's when I went to call the nurse. Review of a facility provided interview completed with NA Employee E1 on 12/23/25, indicated: -(Facility) How did [Resident R1] fall out of bed? -(NA Employee E1) I was providing care, I went to slide the resident towards me so I could turn her the window, I turned her a little bit and pushed her towards the window. Then I forgot the washcloths and soap so I stopped to go to her bathroom to get the supplies. And then I heard her fall while I was in the bathroom and I came out of the bathroom as soon as I heard. -(Facility) Did you receive an assignment sheet? -(NA Employee E1) Yes, I didn't realize she was a 2 assist with bed mobility but I did know she was a 2 assist with transfers. -(Facility) Did you change her earlier today? -(NA Employee E1) I just checked her brief and it wasn't wet so I didn't need to change her earlier, I did find it odd that she wasn't wet in the beginning of the shift but she is alert and oriented and rings when she needs changed. -(Facility) Did you look at your assignment sheet that was given to you at the beginning of the shift? -(NA Employee E1) Yes and I didn't notice she was a 2 assist with bed mobility. -(Facility) Did find it odd that if she was a 2 assist with transfers she wouldn't be a 2 assist with bed mobility.-(NA Employee E1) Yes, now I recognize. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 12/23/25, included the information: -Findings of Facility Investigation: CNA failed to follow residents plan of care with 2 assist for bed mobility. CNA walked away from resident while resident was slightly turned to the right to obtain supplies. This resulted in resident falling out of bed. -Conclusions: CNA failed to follow resident's plan of care which resulted in injury to resident. Review of facility provided information indicated that on 12/23/25, at 5:04 p.m. the facility notified NA Employee E1's employing agency that he was not longer able to work at any facility in their system due to non-compliance with the resident plan of care, which resulted in resident injury. On 12/23/24, the facility initiated a plan of correction that included: Physical and occupational therapy consulted upon return of Resident R1 for bed positioni9ng and safety. NA Employee E1 excluded from further agency employment at the facility or its sister facilities. Resident R1's care plan updated to reflect Resident R1's current status.Staff in-service education related to bed mobility, positioning, and following the plan of care, completed on 12/28/25.Staff in-service education related to abuse and neglect, completed on 1/4/26.Audits completed for safe bed positioning and mobility direct observation of care, daily for one week, three times per week for one week, twice per week for one week, and one time per week for one week. During interviews of eight direct care staff on 1/16/25, confirmed that all staff interviewed had received staff in-service education on abuse and neglect after 12/23/25. Facility was in compliance as of this date. During an interview on 1/16/25, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to protect residents from neglect one of four residents. This was identified as past noncompliance. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to implement interventions to prevent falls for one of four residents (Resident R1). This was identified as past non-compliance.Findings include: Review of the American Congress of Rehabilitation Medicine - Caregiver Guide and Instructions for Safe Bed Mobility published 4/28/17, indicated bed mobility refers to activities such as scooting in bed, rolling, side-lying to sitting, and sitting to lying down. Review of the facility policy, Resident Falls dated 11/24/25, indicated it is the policy of the facility to take all precautions to minimize the risk of falling for all residents and if a fall does occur, to implement appropriate measures to prevent reoccurrence. Review of the clinical record indicated Resident R1 was originally admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 10/28/25, included diagnoses of morbid obesity (chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and muscle weakness. Review of Section G: indicated that Resident R1 required substantial/maximal assistance to roll left and right. Review of Resident R1's current plan of care initiated on 7/24/25, indicated At risk for injury related to falls due to decreased mobility and generalized weakness. Assist x2 for transfers and bed mobility. Review of a progress note dated 12/23/25, at 2:40 p.m. indicated, This ADON (Assistant Director of Nursing) was called to unit by LPN (licensed practical nurse) regarding a fall from bed. Upon arriving to unit, resident was found on the floor lying on her back. Resident was alert and oriented and able to answer questions appropriately. Bleeding also noted to previous left leg wound. Pressure applied to both areas. Review of a progress note dated 12/23/25, at 3:09 p.m. indicated, Resident c/o (complained of) pain in head area. 911 called. Resident remained on floor until paramedics arrived. Resident fell out of bed during care. Order to send out to hospital. Family notified. Review of a progress note dated 12/23/25, at 6:41 p.m. indicated, Received report from [hospital] and spoke to RN. Resident is said to be stable from the fall. Review of facility submitted information dated 12/23/25, indicated, CNA (nurse aide), [Employee E1] was providing care to [Resident R1]. CNA had slightly turned resident onto her right side then walked away from the resident to obtain supplies to provide incontinence care. Resident fell out of bed. RN assessed: Moderate amount of blood noted on left lower extremity from prior wound. No changes in ROM (range of motion), Neurochecks (systematic assessments of the nervous system (brain, spinal cord, nerves) evaluating mental status, cranial nerves, motor strength, sensory function, coordination, and reflexes to detect issues with movement, feeling, balance, awareness, or cognition) WNL (within normal limits). Resident did complain of neck pain when paramedics arrived. Review of emergency room physician documentation dated 12/23/25, at 6:53 p.m. [Resident R1] presents to the ED (emergency department) from skilled facility after she had a fall out of bed with head injury. She is complaining of pain in her head, neck, shoulder, back, also has bleeding through the bandages on her chronic left wound. Review of the facility provided unit assignment sheet in use on 12/23/25, indicated Resident R1: BED MOBILITY: 2 ASST. Review of an employee statement written by NA Employee E1 dated 12/23/25, indicated, I was doing care on resident. I went to slid her toward me then roll her towards the door. I roll her halfway towards the window then I went for a wash rag and towel then I hard to resident fell on the floor. I ran to check on the resident then ran to the door the other aide came in that's when I went to call the nurse. Review of a facility provided interview completed with NA Employee E1 on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/23/25, indicated: -(Facility) How did [Resident R1] fall out of bed? -(NA Employee E1) I was providing care, I went to slide the resident towards me so I could turn her the window, I turned her a little bit and pushed her towards the window. Then I forgot the washcloths and soap so I stopped to go to her bathroom to get the supplies. And then I heard her fall while I was in the bathroom and I came out of the bathroom as soon as I heard. -(Facility) Did you receive an assignment sheet? -(NA Employee E1) Yes, I didn't realize she was a 2 assist with bed mobility but I did know she was a 2 assist with transfers. -(Facility) Did you change her earlier today? -(NA Employee E1) I just checked her brief and it wasn't wet so I didn't need to change her earlier, I did find it odd that she wasn't wet in the beginning of the shift but she is alert and oriented and rings when she needs changed. -(Facility) Did you look at your assignment sheet that was given to you at the beginning of the shift? -(NA Employee E1) Yes and I didn't notice she was a 2 assist with bed mobility. -(Facility) Did find it odd that if she was a 2 assist with transfers she wouldn't be a 2 assist with bed mobility.-(NA Employee E1) Yes, now I recognize. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 12/23/25, included the information: -Findings of Facility Investigation: CNA failed to follow residents plan of care with 2 assist for bed mobility. CNA walked away from resident while resident was slightly turned to the right to obtain supplies. This resulted in resident falling out of bed. Resident was sent to [hospital] ER. -Conclusions: CNA failed to follow resident's plan of care which resulted in injury to resident. Review of facility provided information indicated that on 12/23/25, at 5:04 p.m. the facility notified NA Employee E1's employing agency that he was not longer able to work at any facility in their system due to non-compliance with the resident plan of care, which resulted in resident injury. On 12/23/24, the facility initiated a plan of correction that included: Physical and occupational therapy consulted upon return of Resident R1 for bed positioning and safety. NA Employee E1 excluded from further agency employment at the facility or its sister facilities. Resident R1's care plan updated to reflect Resident R1's current status.Staff in-service education related to bed mobility, positioning, and following the plan of care, completed on 12/28/25.Audits completed for safe bed positioning and mobility direct observation of care, daily for one week, three times per week for one week, twice per week for one week, and one time per week for one week. During interviews of eight direct care staff on 1/16/25, confirmed that all staff interviewed were aware of how to learn a resident's appropriate assistance level from the nurse aide assignment sheet and where to find the assistance level in the electronic medical records, and further confirmed that they had received staff in-service education on bed mobility, positioning, and following the plan of care after 12/23/25. Facility was in compliance as of 12/23/25. During an interview on 1/16/25, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to implement interventions to prevent falls for one of four residents. This was identified as past noncompliance. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.